Reduced Fee Application

Thank you for your interest in the Reduced Fee Program offered by Hear Indiana. We are looking for ways every day to serve those in our area who are uninsured and underinsured. The purpose of this application is to determine eligibility for anyone interested in receiving health care at a reduced rate.

The application must be filled out completely with supporting documents. If the application is not completed it will not be processed; however, if you have any questions about how to fill out a section of the application then please ask the front desk.

Parent/Guardian Information

First & Last Name: _____ D.O.B. _____

Email:_____

Address:_____

City:_____ State: _____ Zip:_____ Phone #:_____

Employment Status: [ ] Full-Time [ ] Part-Time [ ] Self [ ] Non-Employed

Are you currently a student? _____ Are you a veteran? _____

Insurance: [ ] Medicaid [ ] Private Insurance [ ] I do not have insurance

Members of the Household

You must list ALL members of the household, including yourself, and ALL sources of income.

Name	Age	Relationship	Income

In order to complete this application, you will need to provide one of the following documents.

[ ] Two most recent paystubs
[ ] Most recent year's tax return (1040 form)
[ ] Unemployment award letter within the last one month

I, the undersigned, attest to the accuracy and truth of the information provided within this application for services. Hear Indiana staff is hereby authorized to verify all information I have provided. If the information is determined to be false and misleading, I understand that Hear Indiana has the right to discontinue my reduced fee rate and I will pay the full fee for the services and equipment received.

I understand that any changes in income and household must be reported to the Office Manager immediately. I will also report changes in address and phone number.

I understand that it is my responsibility to provide documentation and update my application every year or as otherwise requested by Hear Indiana, if deemed necessary, in order to remain an active patient at Hear Indiana.

I understand that the availability of a reduced fee to me is dependent upon Hear Indiana's funding. I understand that this means that at times I may have to pay more for services than has been determined through this Reduced Fee Application. I understand that this is because funding may change or not be available at certain times. I also understand that there may be a cap or a limit on the total reduction of fees for the services and/or equipment received by the patient identified below.

Patient Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

For Staff Use Only

After examination of this applicant's family size, situation, and financial information, it is my decision that this application is [ ] Approved [ ] Denied as of ___/___/_____.

This status shall remain in effect for 1 year from this date unless otherwise noted, at which time the applicant's financial situation will be reviewed to evaluate eligibility.

_____ _____

COO Date